STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
January 26, 1988

ALL-COUNTY LETTER NO. 88-11

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) - STATE COMPENSATION INSURANCE FUND (SCIF)

REFERENCE: ALL-COUNTY LETTER 82-79, DATED AUGUST 10, 1982

This letter supersedes All-County Letter 82-79 and is a reminder that the Employers Report of Occupational Injury or Illness, SCIF 67 IHSS (July 1982) (copy attached), is to be completed by County personnel on behalf of the recipient/employer and forwarded to the appropriate SCIF District Office within five days of the injury or illness of a provider of services. The five-day time frame is specified by the California Labor Code, Section 6410, and the California Administrative Code, Section 14001. A copy of the SCIF District Office addresses and telephone numbers is attached for your convenience.

When the SCIF 67 is not completed and forwarded within the time frame given, the injured employee cannot receive a timely processing of their claim. This may cause benefits to be delayed and an assessment of a ten percent penalty against the County and/or the State Department of Social Services (SDSS) per Labor Code, Section 5814. Also, if the claim is to be contested, the SCIF needs the information on the report in order to testify at the hearing before the Workers Compensation Appeals Board.

To facilitate communication between SDSS, SCIF and the County, please complete the attached contact sheet and forward the name, address and telephone number of your County IHSS Workers Compensation contact person to:

State Department of Social Services
IHSS/CMIPS Unit
744 P Street, MS 6-500
Sacramento, CA 95814

Attention: Ms. Chris Greb

These names and phone numbers will be shared with the SCIF representative for direct contact when necessary.

If you have any questions regarding this matter, please call Ms. Greb at (916) 322-0913.

LOREN D. SUTER
Deputy Director
Adult and Family Services Division

cc: CWDA

Attachments

State Department of Social Services
IHSS/CMIPS Unit
744 P Street, MS 6-500
Sacramento, CA 95814

Please complete and return this form to the above address within 10 days. Thank you.

IHSS workers compensation contact person:

COUNTY _____

NAME _____

ADDRESS _____

CITY _____

TELEPHONE NUMBER _____

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate. Retain one copy for your files and mail the remaining two copies to

STATE COMPENSATION INSURANCE FUND
ADJUSTING AGENCY
PO Box 8000 Stockton, Ca 95208

OSHA Case or File No. _____

California law requires an employer to report within five days every industrial injury or occupational disease which: (a) Results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid

PLEASE NOTE: In addition, if death results or if the injury or illness: (a) Requires inpatient hospitalization of more than 24 hours for other than medical observation, or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Industrial Safety also must be notified immediately by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway

EMPLOYER

1 Recipient's Name

1A. **CONTØU**

2 Mailing Address (Please include city, zip)

2A. Phone Number

3. Location, if different from mail address

4 Recipient of In Home Care

5 State Unemployment Insurance Acct. Number

EMPLOYEE

6 Name

7 Social Security Number

8 Home Address (number and street, city, zip)

8A. Phone Number

9. Sex ☐ Male ☐ Female

10. Occupation (Regular job title, not specific activity at time of injury)

11. Date of Birth ___/___/___ Month Day Year

12. Wages $ ____ ____ per hour
Authorized hours per week ____ ____

12A. Number of hours worked for above recipient within 90 days prior to this injury ____

12B. Date of Hire IHSS ___/___/___ Month Day Year

13. Other Employment? ☐ Yes ☐ No

Name of Employer and Address:

Hours Worked ____
Hourly Wages $ ____

14 Where did accident or exposure occur? (address, city and county)

15. On Employer's premises? ☐ Yes ☐ No

INJURY OR ILLNESS

16 What was Employee doing when injured? (Please be specific. Identify tools, equipment or material the employee was using).

17 How did the accident or exposure occur? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

18 Object or substance that directly injured Employee (e.g., the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.)

19 Nature of Injury or Illness and Part of Body affected

20. Name and Address of Physician

21. If Hospitalized, Name and Address of Hospital

22 Date of Injury or Illness ___/___/___ Month Day Year

23. Time of Day ____ a.m. ____ p.m.

24. Was Employee unable to work on any day after injury? ☐ Yes, date last worked ____ ☐ No

25. Has Employee returned to work? ☐ Yes, date returned ____ ☐ No

26. Did Employee die? ☐ Yes, date ____ ☐ No

27. **IS THE EMPLOYEE A RELATIVE?** ☐ Yes ☐ No If yes, relationship ____

28 Was Injury caused by anyone else? ☐ Yes ☐ No How?
Name ____ Address ____

29. On reverse side list names and addresses of witnesses

30. Date Employer was notified of injury ___/___/___ Month Day Year

31. When will injured return to work?

Location Code | Signature | Title | Date

Address | Phone No Ext.

PLEASE DO NOT USE THIS COLUMN
Case No
Employer No
Industry
Sex
Age
Occupation
Weekly Wage
County
Accident Type
Agency
Agency Part
Supplemental Agency
Nature of Injury
Part of Body
Injury Date
Extent of Injury
Insurance Carrier
Report Lag
Coded By

SCIF 67 IHSS (REV. 11-83)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY

If you are located in the following counties:

Alameda	Marin	San Francisco
Contra Costa	Mendocino	San Mateo
Del Norte	Monterey	Santa Clara
Humboldt	Napa	Santa Cruz
Lake	San Benito	Sonoma

Please Contact:

Thomas Moseley
State Compensation Insurance Fund
P. O. Box 807
San Francisco, CA 94101
Phone #: (415) 565-1621

If you are located in the following counties:

Alpine	Madera	Sierra
Amador	Mariposa	Siskiyou
Butte	Merced	Solano
Calaveras	Modoc	Stanislaus
Colusa	Mono	Sutter
El Dorado	Nevada	Tehama
Fresno	Placer	Trinity
Glenn	Plumas	Tulare
Inyo	Sacramento	Tuolumne
Kings	San Joaquin	Yolo
Lassen	Shasta	Yuba

Please contact:

Patsy Gibson
State Compensation Insurance Fund
P. O. Box 8000
Stockton, CA 95208
Phone #: (209) 476-2654

If you are located in the folowing counties:

Imperial	Riverside	San Luis Obispo
Kern	San Bernardino	Santa Barbara
Los angeles	San Diego	Ventura
Orange		

If provider name begins with A-K:

Please contact:

Dennis Miller (213) 338-3292

If provider name begins with L-Z:

Please contact:

Valentin Alvarado (213) 338-3305

Both located at:

State Conpensation Insurance Fund
P. O. Box 2518
Culver City,CA 90231